DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1165 (Rev. 02/03)

STATE OF WISCONSIN

WISCONSIN MEDICAID
NEWBORN REPORT

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form.

INSTRUCTIONS

1. Type or print clearly.
2. All requested information must be provided.
3. In multiple birth situations, a separate Newborn Report must be filled out for each birth.
4. For more information on newborn reporting, contact Wisconsin Medicaid Provider Services at (800) 947-9627 or (608) 221-9883. Mail or fax completed forms to:

   Wisconsin Medicaid
   PO Box 6470
   Madison WI 53716
   Fax (608) 224-6318

SECTION I — HOSPITAL (OR OTHER PROVIDER) INFORMATION

Name — Hospital (or Other Provider)	Wisconsin Medicaid Provider Number (eight digits)
Name — Contact Person	Telephone Number — Contact Person ( )

SECTION II — NEWBORN INFORMATION

Name — Newborn (First, Middle Initial, Last)	Date of Birth (MM/DD/YYYY)
Sex ❑ Female ❑ Male	Date of Death, if applicable (MM/DD/YYYY)

Multiple Births

❑ Yes ❑ No If yes, complete a form for each birth.

SECTION III — MOTHER INFORMATION

Name — Mother	Address (Street, City, State, and Zip Code)
Medicaid Identification Number — Mother	
Medicaid Identification Number — Case Head	

SECTION IV — AUTHORIZATION

This information is accurate to the best of my knowledge.

SIGNATURE — Hospital (or Other Provider) Representative	Date Signed

Reset Form